PATIENT INTAKE

Name: _____ Date: __ __ / __ __ / __ __

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Email: _____ DOB: __ __ / __ __ / __ __

Emergency Contact: _____ Phone: _____

How did you hear about us? _____

Your personal skin evaluation:

Skin Type: Normal Oily Dry Combination Other:_____

Condition: Texture Sun Damage Acne Pigmented Other:_____

Specific areas of concern:_____

Have you ever had any of the following conditions? (Check all that apply)

- AIDS
- allergy/hay fever
- anemia
- arthritis/rheumatism
- asthma
- back problems/pain
- bleeding problems
- blood disease
- blood transfusion
- bone or joint pain
- cancer
- chemotherapy
- diabetes
- dizziness/fainting
- drug or alcoholism
- epilepsy
- eye injury or disease
- headaches
- heart disease
- head injury
- hepatitis
- high blood pressure
- infection (active)
- kidney disease
- liver disease
- lupus
- melanoma
- mental disorder
- migraines
- mitral valve prolapse
- nervous disorder
- nervousness
- radiation treatment
- respiratory problems
- shortness of breath
- skin conditions
- sinus problems
- swollen feet/ankles
- stroke
- thyroid problems
- tuberculosis
- ulcers
- varicose veins
- venereal disease

List all current medications/supplements:

_____

_____

_____

Allergies (medications, food, latex, sulfa):

_____

_____

_____

Primary Physician (Name& Phone Number):_____

Have you ever had or currently using:

Retin-A or retinoids	Y	N
Accutane	Y	N
Prescription acne medication	Y	N
Birth control pills/patch	Y	N
Steroids	Y	N
Insulin/Diabetic medications	Y	N
Cold Sore	Y	N

If yes: Date:_____

Females: Date of last menstrual cycle

_____/_____/_____

Pregnant/Lactating? Due:_____

Previous Cosmetic Facial Treatments:

Chemical Peel	Y	N	Date:_____
Botox®	Y	N	Date:_____
Dermal Fillers	Y	N	Date:_____
Tattoo/Perm Makeup	Y	N	Date:_____
Facial Surgery	Y	N	Date:_____
Microdermabrasion	Y	N	Date:_____
Cellulite treatments	Y	N	Date:_____
Laser treatments	Y	N	Date:_____
Tanning (last 2 weeks)	Y	N	Date:_____

Which of the following describes your skin type after <u>1 hour of unprotected sun exposure</u>?

_____ Always burns, never tans	Type I
_____ Always burns, sometimes tans	Type II
_____ Sometimes burns, sometimes tans	Type III
_____ Always tans (American Indian)	Type IV
_____ Hispanic, Asian, Mediterranean, Middle Eastern	Type V
_____ Black	Type VI

What medical aesthetic and wellness procedures are you interested in?

Skin Consultation	Botox®/Dysport®
Dermafillers	Hydrafacial MD®
Laser Hair Reduction	Medical Grade Facial Treatments
Laser Skin Resurfacing/Rejuvenation	Microdermabrasion
Microneedling (Dermapen®)	B12 Injection
LED Therapy	HCG Diet
Chemical Peels	B-Complex

<u>I certify that the preceding medical, personal and skin history statements are true and correct. I am aware that it is my responsibility to inform the technician, esthetician, doctor or nurse of my current medical or health conditions and to update this history as a current medical history is essential for the caregiver to execute appropriate treatment procedures.</u>

Signature:_____ Date:_____

Technician Signature:_____ Date:_____